



## STATEMENT OF SUPPORT

For: \_\_\_\_\_ (Name of Dependent)      Covering: \_\_\_\_\_ (Time Frame)

TYPE OF EXPENSE	TOTAL COST OF SUPPORT	AMOUNT PAID BY DEPENDENT	AMOUNT PAID BY MOTHER	AMOUNT PAID BY FATHER
Lodging Furnished*	\$	\$	\$	\$
Food**				
Medical & Dental Care				
Transportation				
Clothing				
Contributions				
Entertainment & Recreation				
Tuition (Room & Board, etc.)				
Other: (List)				
<b>TOTALS</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>	<b>\$</b>

1. Is anyone else (e.g., former spouse or natural parent) providing support on behalf of this dependent? ☐ Yes ☐ No

a. Name of person providing support: \_\_\_\_\_

b. Relationship: \_\_\_\_\_

c. Amount of support provided per month: \_\_\_\_\_

d. By Court Order? ☐ Yes ☐ No

2. Does this person provide coverage for health? ☐ Yes ☐ No

a. Dental? ☐ Yes ☐ No

b. If coverage is provided, please complete the following:

Policyholder's I.D. # \_\_\_\_\_

Policyholder's date of birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Policyholder's insurance company: \_\_\_\_\_

c. Dependent's total expected annual salary? \_\_\_\_\_

3. Is the Dependent employed?

☐ Yes, Full-time ☐ Yes, Part-time ☐ No

If employed, please provide a copy of the Dependent's current Wage and Tax Statement (W-2 form)

4. Is the Dependent a student?

☐ Yes, Full-time ☐ Yes, Part-time ☐ No

a. What is the number of credit hours per term?

b. Name of school/college: \_\_\_\_\_

Location: \_\_\_\_\_

We certify that the figures above are correct to the best of our knowledge.

Dependent's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dependent's (Residential) Street Address \_\_\_\_\_

Parent's Signature \_\_\_\_\_ Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Dependent's City, State and Zip Code \_\_\_\_\_